Witness Name: Rt. Hon. Matt Hancock MP
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UK COVID-19 INQUIRY

FIFTH WITNESS STATEMENT OF THE RT. HON. MATT HANCOCK

I, Matt Hancock, will say as follows:

1. I make this fifth substantive statement in response to a request from the Inquiry dated 12 March 2024 made under Rule 9 of the Inquiry Rules 2006 ("the Request") asking for a witness statement in connection with Module 3 of the Inquiry. As this Inquiry works in modules and accepting the suggestion of the Inquiry in the Request I have copied and repeated paragraphs of my previous Witness Statements to the Inquiry where relevant to the matters under consideration in Module 3 nevertheless this statement has been drafted as a 'stand alone' statement for the purpose of Module 3.

2. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to work on its involvement in the Inquiry, and should any additional material be discovered I will of course ensure that this material is provided to the Inquiry and I would be happy to make a supplementary statement if required.

3. This statement sets out my involvement in decisions relating to the impact of the pandemic on the UK's healthcare system in the period between 1 March 2020 and 28 June 2022, focusing particularly on the period between 1 March 2020 and 26 June 2021, when I was the Secretary of State for Health and Social Care ("Secretary of State").

4. The single most important fact about the NHS in the pandemic is that it was never overwhelmed. We collectively set this objective at the start, and achieved it

throughout. Despite huge pressures, especially in particular areas at particular times, demand never exceeded capacity across the UK as a whole.

5. I would like to take this opportunity to again reiterate my thanks and appreciation for the remarkable efforts of health and social care staff throughout the pandemic. The nation and I owe them a tremendous debt of gratitude.

Personal Background

6. I served as Member of Parliament for West Suffolk from 6 May 2010 to 30 May 2024. I served as Minister for Skills from 2012-2013, and subsequently served as Minister for Skills and Enterprise from 2013-2014. In 2014 I became Minister for Business and Energy, and in 2015 I was appointed Paymaster General and Minister for the Cabinet Office. In 2016 I was appointed Minister for Digital and Culture, and on 8 January 2018 became Secretary of State for Digital, Culture, Media and Sport. I was subsequently appointed and served as Secretary of State for Health and Social Care from 9 July 2018 to 26 June 2021.

7. Prior to my time in Parliament I worked in data analytics, as an economist at the Bank of England, and for the Shadow Chancellor of the Exchequer.

Role of the Secretary of State for Health and Social Care

8. The approach I took in leading the Department was to set the direction in which we needed to go, based on the best available advice, and encourage and empower all involved to take decisions to the best of their ability. As I explained in my second Witness Statement, I tried to lead the Department using some basic rules of thumb:

    a. Delegate authority on a principle of subsidiarity, and take accountability;

    b. Empower the team at all levels to make decisions without fear of reprisal if it goes wrong;

    c. Demand as much information as possible to make a decision, but no more than is possible;

    d. Work as a team, and protect the team from undue interference and distractions;

    e. When something goes wrong, ask not the question 'who is to blame?' but rather 'how can we fix this?'; and

f. Concentrate on saving lives, not how it will look afterwards.

9. I have reviewed Sir Christopher Wormald's tenth witness statement, prepared for Module 3, which gives an overview of the Department's formal structures and the legal obligations of the Secretary of State in relation to the healthcare system.

10. In practical terms, my role and function as Secretary of State in relation to the healthcare system was to set the strategic direction of the healthcare system, secure the budget, and support effective delivery of health and social care. As I explained in a speech to the Royal College of Physicians on 30 July 2020, I saw my job as Secretary of State not to impose some preconceived utopia that might look good on a management consultant's slide deck but bears no relation to reality on the ground, but to make the system work for those who work in the system, and work hard to make the system work: to free up, empower and harness the mission-driven capability of team healthcare by encouraging collaboration, speed and innovation (MH5/1 - INQ000478906).

11. My daily work was heavily diarised, and run by my Private Office. Before the pandemic, I would hold regular - usually weekly - meetings on the areas of responsibility I wanted to drive hardest. For example, in late 2019 I would have regular weekly meetings on:

    a. The NHS - with Sir Simon Stevens on the management of the NHS;

    b. Technology - improving health technology and use of data;

    c. People - improving the way the NHS recruits and rewards staff;

    d. Prevention - driving the agenda to prevent disease, not just react to it;

    e. Media - to consider communications, including public health communications;

    f. Ministers - to stay in regular contact with Ministerial colleagues; and

    g. Cabinet - chaired by the Prime Minister in No10.

12. I would also hold regular meetings on ad hoc topics, such as delivering on manifesto commitments, securing Departmental finances, hosting visiting dignitaries, making statements in Parliament and other speeches to drive forward progress, responding to questions in Parliament, undertaking media appearances, attending cross-Government meetings such as Cabinet Committees or COBR, delivering a myriad of

specific projects, like access to Orkambi (a drug to help those with cystic fibrosis), or making visits across the UK and occasionally overseas to represent the Government and listen and learn.

13. In addition to meetings, many decisions were made through paperwork. The primary method of decision making throughout my period as Health Secretary - including in the pandemic - was the formal Departmental submission: a detailed note from the Civil Service, considering an issue from all angles, that would usually put forward options for decision. Cross-Government matters were largely dealt with through formal letters setting out a Department's position, to seek a cross-Government agreed position. Normally I would receive around twenty submissions or letters per day, typically in my evening red box (my 'box'). On top of each submission, Private Office would attach a one-page note which included:

    a. the date of submission;

    b. the deadline for response;

    c. a summary of issue and decisions needed, and any interaction with other relevant work;

    d. the view of the Junior Minister responsible for that area; and

    e. any views from Special Advisers.

14. I split my box into five files:

    a. Constituency matters relating to my role as MP for West Suffolk;

    b. urgent matters (I always completed this file overnight);

    c. routine submissions for decision (I usually completed this overnight);

    d. reading materials not for decision; and

    e. diary questions and invitations.

15. My box would typically take an hour to ninety minutes each day. In addition to this, I would talk to colleagues in person and on the phone, and use email and messages in a fairly limited way. Sometimes I would write on a submission itself and then

photograph the submission with my notes and send to my private office when this was the most efficient way of sending back my views.

16. During the pandemic my ways of work changed in the following ways:

    a. I would wake at 6am and spend half an hour checking urgent overnight messages and news;

    b. Most days, my driver would collect me each day at 07:50 and I would arrive at the Department of Health and Social Care at 08:20;

    c. I would have back-to-back meetings throughout the day, in the Department, 10 Downing Street or Parliament, usually going back home at around 7-8pm, but often later into the evening;

    d. I would have a short time to have dinner with my family before going back to my home office to continue working until around 11 o'clock at night. I always tried to get to bed by midnight;

    e. Across Government we used WhatsApp far more frequently, as there were fewer in-person meetings across Whitehall, and the necessary speed of decision taking increased radically. Decisions that previously may have been made in a meeting scheduled several weeks hence would be discussed by WhatsApp and formally taken at urgently convened meetings. WhatsApp presented a very effective, socially distanced way of communicating directly with people, though I do note the government business was not decided over messages;

    f. I spoke regularly to the Prime Minister by phone to keep him abreast of developments;

    g. A weekly G7 call with my Health Minister counterparts was set up each week to discuss how the pandemic was evolving overseas. Ad hoc bilateral international discussions became more frequent;

    h. I set up a weekly 'Four Nations' call with my Scottish, Welsh and Northern Irish counterparts to ensure we had as coordinated a response as possible across the UK; and

i. Administratively, the Permanent Secretary at the Department Sir Chris Wormald, diverted his entire attention to COVID-19 on 22 January, delegating the day to day running of the Department for non-COVID purposes to David Williams, who was appointed Second Permanent Secretary of the Department on the 6 March.

Role of the Department during the pandemic

17. The scale of the pandemic meant that the UK's healthcare system faced an unprecedented challenge in terms of both size and complexity. Everyone had to pull together and work together in new ways to deliver for the patients and the public. The virus impacted our society unequally, and at the centre of our response was a desire to protect those most vulnerable to COVID-19. This required huge sacrifice from the general public and particular sacrifice from health and social care workers, for which I am very grateful.

18. I worked in close partnership with Sir Simon Stevens, the CEO of NHS England throughout the pandemic.

19. From January 2020 it was clear that there was a potential need for a very significant NHS response. During February 2020 it became clear this risk was materialising. As I explained in my second witness statement, on 27 February I met with No10 officials to discuss the structure of domestic response, supply and communications. A read out of the meeting was subsequently circulated (MH5/2 - INQ000049457). After that meeting I met with Sir Chris Wormald to discuss governance structures for the response to the coronavirus. The note of that discussion records that:

> *"SofS outlined that he will be leading the response to Coronavirus as SofS of the Health and Social Care system and will also be leading the coordination across Government to support [other Government Department] ministers to consider the impacts on their services (for instance schools, businesses). SofS decided as chair that he would like to step COBR up to twice a week.*
>
> *The Governance structure is as follows:*
>
> - *Twice weekly COBR – M meetings, chaired by SofS;*
> - *Twice/three weekly COBR – O meetings;*

- *A designated Junior Minister from every Department that works on Coronavirus;*

- *All DHSC junior ministers to have a role to play on Coronavirus;*

- *Daily meetings with the health system (PHE, DHSC, NHSE officials);*

- *Daily conversations with the CMO;*

- *Some PM oversight, he's open to discussion but perhaps a weekly call with the PM could be useful;*

- *A weekly press briefing that will be led by SofS and CMO (joined by lead officials depending on situation).*" (MH5/3 - INQ000049458)

20. The decisions we had to make were completely novel, so I worked much more closely with the leadership of the NHS than in normal times, generally speaking several times each day, because we needed each other's skills and expertise. Many decisions were cross government in nature – for example when using military resources to deliver testing and vaccine capabilities – so the NHS could not operate as autonomously as in normal times.

21. The Inquiry has asked if my role as Secretary of State and the role of the Department changed from strategic roles to include operational responsibilities in relation to the health system during the course of the pandemic. The role of Health Secretary always has an operational element, particularly in crises. For example, chairing COBRA regularly involves deeply operational decisions. However, inevitably this operational responsibility expanded. Formal operationalization of decision-making relating to the health system remained the responsibility of the NHS, but the Department needed to understand operational feasibility in order to take strategic decisions, and the very close working relationship I have described above was developed to fit the needs. The Department dramatically expanded its internal capability to deal with issues and challenges posed by the pandemic over the course of my time as Health Secretary.

22. I instigated daily meetings with the health system in the Department, and a weekly systems leaders overview meeting. I spoke to front line healthcare workers wherever possible, and held regular discussions – formal and informal - with Royal Colleges, the BMA and RCN to get feedback. Obviously huge numbers of clinicians and experts also advised the Department formally, many of whom continued to practice on the front line.

23. I worked extremely closely with the Chief Medical Officer for England ("CMO"). We had regular meetings and discussions, from first thing in the morning to last thing at night. He provided regular advice, for example, talking me through what had happened at SAGE meetings. Because he was based in the Department, he would sometimes ask for a word in my office, or I would go to his, and I would phone him and ask for advice.

24. I had regular contact with Duncan Selbie, the Chief Executive of Public Health England ("PHE"). He attended the Department's daily coronavirus meetings, and we also had scheduled one-to-one meetings.

25. In addition to an effectively constant dialogue with Sir Simon Stevens, who was CEO of the NHS for almost the entire period. I had formal meetings with Simon Stevens and Amanda Pritchard of NHS England, on a regular weekly basis. These were called 'quad' meetings, because Simon and Amanda met with me and the Permanent Secretary. These quad meetings predated the pandemic, but continued throughout the period covered by this statement. These meetings were a very effective way that we could work together to respond to the pandemic. It meant that any issue that needed discussion could be discussed within a week. Obviously there were many times when decisions had to be taken, and were taken, much, much faster. For example, at a quad meeting on 27 January 2020 coronavirus plans were the first thing I asked about. Later at that meeting, Simon Stevens agreed to look into planning for converting wards to become available for use for infectious diseases, as the current available capacity was for 511 infectious people (MH5/4 - INQ000478851). Sir Simon Stevens also attended ad-hoc meetings in the Department as and when particular issues needed to be resolved, and we would hold discussions with the Prime Minister, and in the margins of meetings with the Prime Minister, several times a week. This dialogue, as well as daily data updates on NHS performance, were the primary means by which I was kept informed of the NHS's ability to cope with the response to the pandemic, as well as its broader performance.

26. I worked closely with Dame Ruth May, the Chief Nursing Officer for England. She was particularly helpful in aiding the Department in liaising with the Royal College of Nursing and helping with policy relating to 'on the ground' decisions, for example requiring masks in hospitals.

27. Throughout the pandemic I had regular meetings with bodies representing the interests of healthcare workers, including the British Medical Association, Royal

College of Nursing and Royal Colleges. I had strong relations with the leadership of all of these organisations, and valued their input. I also valued the input of the TUC, although by its nature their input was not as frequent.

Relationship with Ministerial Colleagues

28. Many decisions relating to the healthcare system's response to COVID-19 were not constrained by or contingent upon other Cabinet ministers or government departments. But many decisions were entirely contingent on collective action, and I worked in close collaboration with the Prime Minister and my Cabinet colleagues throughout.

29. While I was initially frustrated by the Cabinet Office's response – for example in refusing my initial request to hold COBR meetings, and holding up the Action Plan that was eventually published on 3 March – once the scale of the problem became evident to them, and especially after the arrival of Simon Case and the instigation of the COVID-O and COVID-S system, cross government working was broadly effective. I do not consider that inappropriate political interference from No10 related to issues in the scope of this Module. I was not aware that certain individuals in the Cabinet Office and No10 were being as unprofessional and unhelpful to the pandemic response as I have discovered subsequently.

Relationship with Devolved Health Ministers

30. I worked closely with my counterparts in the devolved administrations throughout the pandemic. On 12-13 March 2020 I visited the three devolved health ministers to build relationships, because I knew we would need to work together throughout the pandemic.

31. I flew to Edinburgh and met with Jeane Freeman, Scottish Cabinet Secretary for Health on the evening of 12 March 2020. The next morning I then flew to Belfast and met Robin Swann, the Minister for Health for Northern Ireland. That afternoon I flew to Wales and met Vaughan Gething, now First Minister and then Health Minister for Wales. The briefing pack I received for these meetings suggested possible areas to cover with each Minister, and an overall emphasis of my approach, which was open and collaborative. I wanted to make sure we were working together closely.

32. In the meetings we discussed each Minister's concerns about the potential impact of the virus on their nation's health system. For example, in my meeting with Robin

Swann we discussed routine arrangements in Northern Ireland for specialist intensive care provision.

33. My Private Secretary's note of these meetings is (MH5/5 - INQ000279751). The Inquiry has asked if there were any divergences of view in these meetings. My view is that there were not – we were united in our desire to work together to keep people safe and protect the vulnerable. My Private Secretary's note records that Jeane Freeman and I discussed mass gatherings, as she had announced earlier that day that the Scottish Government would advise the cancellation of events with over 500 people from 16 March 2020 because of the impact of mass gatherings on the capacity of the emergency services. I don't consider this a divergence of view between the two of us, and as the note records, during the call I noted my hope that we could speak in advance of future measures to reach a 'Four Nations' approach, hence my establishment of the weekly call discussed below.

34. These visits helped build a sense of common mission among the leadership of the four nations. Previously there was no formal mechanism for co-operation across the four nations among Health Ministers, and we all represented different political parties. Co-ordination existed at CMO level, and also at First Minister level, but I felt the lack of health minister co-ordination was a missing piece of institutional infrastructure. Given the devolved nature of health policy, but the cross-border impact of the pandemic, this was clearly critical, so as UK Health Secretary, I took the lead in discussing this with my counterparts in the Devolved Governments, leading to the weekly calls which took place throughout the rest of the pandemic and were vital for coordinating across the four nations.

35. The weekly 'Four Nations' calls were on average half an hour long. The Inquiry has asked about what was discussed on these calls; regular topics of discussion included the strategy for exiting lockdown, PPE, testing and adult social care (MH5/6 – INQ000279759; MH5/7 – INQ000279763; MH5/8 – INQ000485158; MH5/9 – INQ000279766).

36. I have been specifically asked about a note of a COVID-19 update meeting I held with departmental officials at 1:15pm on 14 April 2020 (MH5/10 - INQ000292607). The note records that I asked about PPE in Scotland. There had been reports in the media that supplies of PPE to care homes in Scotland were being diverted to England (MH5/11 - INQ000354165).

37. There had been an issue with the wording on one wholesale supplier's website, which suggested that Public Health England restrictions meant they could not supply PPE to domiciliary and care homes in Scotland and Wales (MH5/12 – INQ000485154). My officials asked the supplier to update the wording on their website (MH5/13 - INQ000478875). The website was updated and clarified:

> *"These pandemic English pandemic flu stocks are mandated for supply to CQC registered settings operating in England. Currently there are only 3 products from over 2000 that this relates to. We continue to supply on a daily basis our full range (less these 3 products from Public Health England) to Care providers in Wales and Scotland."* (MH5/14 – INQ000485155)

38. I wrote to Jeane Freeman on 17 April 2020 and explained:

> "*each devolved nation has its own pandemic influenza stockpile which it has allocated to its own providers. In England, PHE allocated a portion of England's stockpile to primary care and social care providers and used private sector wholesalers as the route to market. It is only for this portion of the stock (masks, aprons, gloves) that we ask these wholesalers to supply England in the same way that the Scottish stockpile is used in Scotland. If any of these wholesalers source their own stock of these items, they are, of course, free to supply across all the countries. My officials are working with [the supplier] to update their website to ensure it is clear.*" (MH5/15 - INQ000478878)

39. I received a letter from Jeane Freeman on 17 April 2020 which noted that the issue had arisen because of an erroneous message on one PPE supplier's website (MH5/16 - INQ000478879).

40. We had a call with the four nations' health ministers on 20 April 2020. My briefing for that call records that a weekly four nations PPE oversight board had been set up to manage demand and supply and ensure supplies are distributed equitably across the four nations (MH5/17 - INQ000478880). What all this shows is that Jeane and I effectively worked through an issue that could be a potential source of tension, with the common goal of the best outcome for the public. Naturally her focus was on supplies in Scotland; my responsibility was both to England and with my overarching responsibility across the whole UK. While these differences of responsibility and therefore perspective were important considerations, I believe that in this case, and in all cases with respect to devolved Health Ministers during the pandemic, we put

the safety of the public first. I consider Jeane Freeman, Robin Swann and Vaughan Gething first rate public servants who served their nations with distinction during the pandemic.

41. The Inquiry has asked whether there were any significant differences of approach to the pandemic between the four nations during my tenure as Secretary of State. I do not believe that there were; each health system faced its own challenges and at times would adapt its approach in line with local need. Occasionally there were presentational and political differences between politicians involved, but all shared a common commitment to being guided by the science and protecting the most vulnerable.

Asymptomatic Transmission

42. I have been asked about asymptomatic transmission. I have covered this subject extensively in my second and third witness statements, and again invite the Inquiry to consider the statements from the Chief Medical Officer ("CMO") about asymptomatic transmission (his First Witness Statement at paragraphs 6.55 to 6.63 and his Fourth Witness Statement at paragraphs 5.19 to 5.25). As the CMO makes clear, it was a gradual process of accumulation of evidence that led to asymptomatic transmission being considered a major part of the force of transmission of the virus. I agree with the views set out by the CMO, which should not be surprising as we discussed it regularly during this period.

43. From January 2020 I was concerned about the extra risks that would be posed by asymptomatic transmission. On 26 January I read a report from China of the possibility of asymptomatic transmission, which I found particularly worrying (MH5/18 - **INQ000183872**) The case definition (a clinical statement of the best known understanding of the virus and the disease it caused) included an assumption of no asymptomatic transmission. I asked officials for advice on this for the next day's meeting.

44. At this stage PHE was adamant that a coronavirus could not be passed on asymptomatically and that tests did not work on people without symptoms. I wanted to use the meeting to push them on both of those critical points and to leave them in no doubt that we needed to expand testing.

45. On 27 January 2020, I raised concerns with officials about asymptomatic transmission. My Private Secretary's note of that meeting records:

> *"• SofS opened the meeting by outlining his concern upon hearing that the virus is transmissible when patients are asymptomatic and set out the need to plan for the reasonable worst based scenario.*
>
> *• CMO commented that previously our best understanding was that the virus was unlikely to transmit whilst patients were asymptomatic (but this was/is unable to be definitive). There is still a lack of clarity over what the Chinese official position is. CMO would expect that very symptomatic persons would equally be very likely to transmit the virus. CMO commented that if transmission was occurring rapidly in the UK, it would be highly likely that this would have come from highly symptomatic persons. CMO was confident but could not guarantee that asymptomatic persons would be less contagious than heavily symptomatic persons.*
>
> *• CMO commented that current intel suggests that the coronavirus is a moderately severe upper respiratory tract infection. The fact that mortality rates appear to be levelling out imply that our certainty on the gravity of the situation is improving, but this is caveated by our reliance on information from China.*
>
> *• SofS asked the Department to gain clarification from China on whether asymptomatic transmission is occurring, and to scenario plan accordingly."* (MH5/19 - INQ000478852).

46. Further on 27 January 2020, Germany confirmed its first case of the virus with a patient who reported feeling ill on 23 January and seemed to have caught it from her parents who had been to Wuhan and tested positive even though they showed no symptoms. I spoke to Jens Spahn, my opposite number in Germany, who I trusted. He told me that the evidence of asymptomatic transmission was tentative but that the German authorities were worried and keeping a close eye on it.

47. At a meeting on 28 January 2020 I was told that a paper on asymptomatic transmission was being prepared and would be provided to me later that day.

48. On 29 January 2020, following PMQs, the CMO asked to see me, and proposed four elements for our response to the virus: first, we try to contain isolated outbreaks, then we try to delay the spread. If containment is unsuccessful and the virus spreads to

the general population, we move on to mitigating and slowing its effects; and throughout we research for treatments and a vaccine. Once again I pushed PHE about asymptomatic transmission; the paper I had been provided with said almost nothing and did not even contain a provisional finding. I could not understand why it was taking so long to get an answer on this issue, not just in the UK but around the world. I called Tedros Ghebreyesus again to have another go at persuading him to declare a PHEIC (MH5/20 - **INQ000107070** my sense was that he was terrified of upsetting Beijing. I asked him about unofficial reports from China that there was asymptomatic transmission and he played it down, said that it was a translation error, and claimed to be impressed by the Chinese authorities' transparency. I found this response surprising.

49. Despite these discussions, the global scientific consensus remained that there was no proof of asymptomatic transmission, and that policy should be based on this assumption. For example, even as late as 2 April 2020, the WHO restated their position that there had been no documented asymptomatic transmission. (MH5/21 - INQ000074894)

50. On 3 April 2020, the day after the WHO's announcement, the US Center for Disease Control published a study which demonstrated that asymptomatic transmission was likely to be occurring, with over 50% of residents in one care home having been asymptomatic but tested positive for Covid-19 (MH5/22 - INQ000348269). The minute I heard this news, I instructed the Department to review all of our guidance.

51. During the period from January until 3 April 2020, I repeatedly raised my concerns about the potential for asymptomatic individuals to infect others with those advising me. However, up to that point I was repeatedly advised by PHE both that we should not assume asymptomatic transmission, and that testing those without symptoms would not confirm that they did not have the virus, and so could be counter-productive.

52. I wanted to introduce testing into health and care setting as early as possible. Because of the huge amount of work I led to expand the availability of testing, this happened as soon as it possibly could. The order of priority of access to tests was always determined by clinical advice.

53. On 4 April 2020 the Government published its 'COVID19 – Scaling up our Testing Programmes' strategy. This included our aim of increasing testing levels to 100,000 tests per day by the end of the month.

54. I have been asked about the 'possible conclusions' section in my Chair's brief for the healthcare ministerial implementation group ("HMIG") on 9 April 2020, which stated:

> *"In line with the model, we must ensure that staff in care homes can access tests quickly, as this links directly to NHS capacity. I will make sure this is communicated clearly."* (MH5/23 - INQ000083647)

55. Enabling care home staff to access COVID-19 tests was linked directly to NHS capacity, because the prioritisation of tests was an important clinical question, and tests were in short supply. I did all I could to increase testing capacity as rapidly as possible.

56. On 10 April I announced that we had capacity for all key social care staff and NHS staff who needed to be tested to get a test (MH5/24 - INQ000478869).

57. On 14 April 2020 I received updated advice from Sir Chris Whitty that he was now recommending testing asymptomatic people going to care homes from hospital, which I regarded as a very significant step forward (MH5/25 - INQ000093326; MH5/26 - INQ000292604; MH5/27 - INQ000292605). On 15 April 2020 I had succeeded in driving testing up to 38,766 per day, and we were able to announce that all patients being discharged from hospitals into care homes should be tested. There was subsequently a change in scientific advice due to operational constraints, as I discussed in my third witness statement at paragraph 53d. Testing was extended to asymptomatic care home staff on 28 April 2020.

58. On 20 April 2020 I met with officials and emphasised the need to get going on survey testing in hospitals, including asymptomatic staff. My Private Secretary's note records that the Permanent Secretary raised a previous meeting with the Chief Medical Officer and noted that there remained a number of unknowns from a scientific perspective (MH5/28 - INQ000478882).

59. Following the CDC's evidence, PHE began their own study which supported the American evidence. That was presented to NERVTAG on 24 April 2020.

60. On 26 April 2020 I received a written update from officials on asymptomatic swab testing. That paper noted, emphasis added, *"PHE has confirmed there is no barrier*

to testing symptomatic people in any setting or to including asymptomatic people where clinically appropriate. In the first instance, this will include: expanding testing to all hospital admissions to help guide improved infection control; testing more people in care homes when outbreaks occur, whether they are symptomatic or not; as well as staff in care environments to understand the prevalence of asymptomatic disease and develop protocols to minimise the number of staff in these environments who are potentially asymptomatically infectious." (MH5/29 - INQ000478887)

61. Further evidence was presented to SAGE on 12 May 2020 and informed Covid-19 response plans. But even before this official advice was given to Ministers, we took the decision to act on the assumption of asymptomatic transmission after seeing the CDC evidence.

HCID

62. Professor Sir Chris Whitty's second witness statement at paragraphs 5.26 and 5.27 explains:

> *"A novel emerging infectious disease is likely to be treated as an HCID whilst the characteristics of the pathogen are still becoming known. Wuhan novel coronavirus was classified as an HCID on 16 January 2020 and declassified on 19 March 2020, following advice from ACDP. These decisions took into account the available information and uncertainty about this novel disease at the beginning of the outbreak and mortality rates among other factors.*
>
> *There are significant disadvantages to a disease being classified as a HCID when it is not one. At the individual patient level it makes treatment more difficult and alarming as very strict barrier care will be in place, and ill patients may have to be transported around the country to specialist units with attendant risks. At an NHS-wide level each case of a HCID is highly resource-intensive, and the specialist provision of beds is limited. At a population level contacts will be very strictly isolated and monitored. There are therefore few advantages, and several risks, to having a HCID classification in place when it is not needed. De-classifying diseases down to a non-HCID wherever possible should therefore be seen as normal practice once initial risk assessments are in place."*

63. Sir Christopher Wormald's third witness statement at paragraph 208 explains that on 19 March 2020 UK public health agencies declassified COVID-19 as a High Consequence Infectious Disease ("HCID"). I had no role in this decision.

Healthcare Capacity

64. During January it was clear that the novel pathogen presented a potential risk that might require significant NHS capacity. This risk became more likely to materialise during February, as the likelihood of a global pandemic grew. At first the reasonable worst case scenario assumptions were based on a pandemic flu, and given the unknowable nature of a novel pathogen, this was appropriate advice. However, the advice also assumed that in a reasonable worst case scenario, significant numbers of NHS staff would be ill, so physical capacity would not be a limitation. This assumption was wrong, for a number of reasons.

65. First, staff ratios could be, and indeed were, stretched so that the same number of staff could care for more patients. I suggested to Sir Simon Stevens that ratios be stretched to ensure everyone could access treatment, and the NHS implemented this as measures were taken to expand capacity.

66. Second, because the disease required a high concentration of specific equipment – notably respirators – there were physical constraints to capacity.

67. Third, the decision to lock down, as opposed to simply manage the impact of the disease, meant that there were not as many ill members of NHS staff than in the reasonable worst case scenario.

68. Therefore it was possible to expand NHS capacity. When I reached this conclusion in March, and realised the assumptions embedded in the preparedness strategy was wrong, I immediately requested the NHS expand its physical capacity, which it did, brilliantly, through the Nightingale hospital project, overseen by Amanda Pritchard. Further capacity was a vital insurance against the pandemic being even worse than it was. With hindsight some have made the case that the Nightingale project was not necessary. This is both an error of fact, as between 19 March 2020 and 6 April 2021, 381 people were admitted to a Nightingale hospital with Covid, but more importantly, it is a conceptual error. When I commissioned the Nightingale hospitals, it was unknowable how bad the pandemic would get. The worst case scenario was coming true, and we didn't know what the impact of lockdown would be. We should be incredibly proud of the Nightingale project, not just on behalf of the 381 people who directly received treatment, but because they were ready should the pandemic have been even worse. I was supportive of efforts to use and re-purpose

Nightingale facilities, for example to support the vaccine program and address the backlog in elective services, but these were operational decisions for the NHS.

69. In terms of chronology, as I explained in my second witness statement, on 2 March 2020, I was briefed that SAGE had updated the reasonable worst-case scenario with the latest international data and reduced the maximum number of deaths from 820,000 to a still horrific 520,000 out of 53.5 million people showing symptoms. Around 390,000 of those might be in critical care with such bad breathing problems that they need ventilators. These figures were only stopped because of the imposition of lockdown, but we had no idea how quickly lockdown would get the numbers down, or indeed if lockdown measures would ever get R below 1.

70. On 4 March 2020, NHS England declared Covid-19 their highest grade of emergency, a Level 4 alert. This meant that Sir Simon Stevens took command of all health service resources in England. Sir Simon discussed this decision with me in advance and I was happy with it. Guidance for hospitals told them to assume they would need to look after Covid-19 cases in due course. In addition, a rule was introduced that everyone in intensive care with a respiratory infection must be tested for Covid-19. It was understood that there would be too many patients to treat on specialist Covid-19 units, so the Department had said that people could be cared for in wider infectious disease wards. At this point SAGE had advised that we were around 4 weeks behind Italy on the epidemic curve. Italy indicated that they would close all schools and universities, while Germany declared an epidemic and shifted from containment to mitigation.

71. On 4 March 2020 I had further meetings with the PM and officials to discuss the way forward and the latest data from SAGE; I had been clear the day before that we needed to dramatically increase testing capacity and protect vulnerable people, which we discussed (MH5/30 - INQ000049512; MH5/31 INQ000049513; MH5/32 - INQ000087584; MH5/33 - INQ000087585; MH5/34 - INQ000049516). The Inquiry has asked who was present at the meeting where (MH5/32 - INQ000087584), a SAGE paper, was discussed. My Private Secretary's note records the meeting's attendees: Clara Swinson; Keith Willett; Emma Reed; Yvonne Doyle; the Minister of State for Health, the Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care; Jonathan Van Tam; Lord Bethell; Hadley Beeman; Paul Cosford; Emma Dean; Allan Nixon; David Lamberti; NR Wendy Fielder; NR NR NR NR

NR David Halpern and I were present. The discussion of the SAGE paper was led by Professor Sir Jonathan Van Tam, see (MH5/30 - INQ000049512).

72. On 9 March 2020 I received a briefing about NHS bed demand and reasonable worst case scenario modelling (MH5/35 - INQ000146571).

73. On 12 March 2020. Sir Simon Stevens called to propose postponing all non-urgent operations from 15 April to free up 30,000 beds. To me this really hammered home what was coming. All those people waiting for surgery, many in pain, would now be deferred. The NHS argued that frail, elderly patients who did not need urgent treatment would need to be discharged, either to their home or to care homes.

74. I received briefing from my officials of the impact of this policy based on NHS modelling. The briefing explained "*NHSEI's bed modelling suggests a shortfall of up to 800,000 beds if there were no mitigating actions. In the 'best case' there are 100k beds required. This is the maximum number of beds available at acute hospitals, but NHS estimate only 30k beds available to be freed up, implying 70k taken up by non-elective care that can't be stopped.*" (MH5/36 - INQ000109139)

75. The result of all of these decisions was that at no stage was I advised that intensive care capacity was exceeded. I understand that there may have been some individual hospitals where intensive care capacity was exceeded, and patients needed to be transported elsewhere, but there was capacity in the system as a whole.

76. I have been asked to provide further detail about which hospitals or NHS Trusts exceeded capacity including the dates when this occurred, how such matters were communicated to the Secretary of State and when. A submission I received on 23 March 2020 recorded that "*on 20 March, Northwick Park Hospital declared a critical incident as it ran out of critical care capacity. Other London Trusts are under very great pressure. While Trusts can work together through their critical care networks to balance demand and supply (as Northwick Park did in this case), ultimately such capacity is finite.*" (MH5/37 – INQ000485149). The submission requested support for what became the Nightingale project discussed above, and underscores why the Nightingales were a vital tool in increasing capacity and the resilience of the healthcare system. The NHS will be better placed to advise about the particular areas where there were pressures, including particular times, waves, or dates.

77. The NHS also used private hospitals to increase capacity. I considered this value for money because any additional capacity we could use in the system would save lives

and prevent the system from being overwhelmed. Independent sector capacity was also used for critical non-COVID related healthcare, for example cancer diagnosis and treatment (MH5/38 – INQ000485160).

78. Commissioning private hospitals and contractual negotiations were matters for the NHS. Efficient contracting and use of independent sector capacity were regularly reviewed, including by the Department and the Treasury. For example, I received a briefing about the initial independent sector arrangements on 22 May 2020, which included utilisation data and case studies about how independent sector capacity had been used (MH5/39 – INQ000485161). This briefing recorded that between 23 March 2020 and 10 May 2020 the Independent Sector's activity included:

    a. Approximately 7,300 non-elective admissions;

    b. Over 111,000 outpatient attendances;

    c. Over 4,300 ordinary elective admissions and;

    d. 12,900 day case elective spells;

    e. Over 19,000 diagnostic imaging tests;

    f. Approximately 2,900 chemotherapy treatments.

79. The briefing also noted "*In all reasonable scenarios there is not sufficient capacity to deal with non-elective and elective activity at normal volumes [without using independent sector capacity]. Elective activity would have to be permanently limited to critical cases and even then that would be insufficient to deal with the winter peak. Extra capacity of at least 10,000 G&A and up to 2,500 additional critical care beds will be needed through 2020/21 to enable return to normal activity volumes, even without the impact of any future peak in Covid-19 cases.*"

80. During negotiations in November 2020 I noted at a quad meeting that I would like to drive the independent sector as hard as possible for as much value for money as possible (MH5/40 – INQ000485164).

81. Throughout this period we were concerned about not just the direct lethal threat of COVID-19, but also indirect mortality: patients because they had not been able to get treatment for other conditions. Public messaging therefore made clear the need for patients to access the NHS for non-COVID-19 purposes. Clearly, the more we

managed to reduce the spread of COVID-19, the better for patients of non-COVID-19 disease too. I was acutely aware of the need to ensure both messages got across. For example on 22 April 2020 I made a speech in Parliament emphasising that the public should continue to come forward for the non-COVID-19 services they needed. I said:

> *"I want to reinforce the message that non-covid NHS services are open for patients: the NHS is there for you if you need advice and treatment. I want to address that message very clearly to those who might be vulnerable to heart attacks or stroke, to parents of young children, to pregnant women and to people with concerns that they may have cancer. I want to emphasise that people with non-coronavirus symptoms must still contact their GP. If you think you need medical help, please contact your GP, either online or by phone, to be assessed. If you need urgent medical advice, use NHS 111 online; if you cannot get online, call 111. And, of course, if something is serious or life-threatening, call 999. If you are told to go to hospital, the place you need to be is in hospital. The NHS is there for you and can provide the very best care if you need it."* (MH5/41 - INQ000421417)

82. This message was repeated in a number of different ways that week, see for example a Tweet I sent on the same day and remarks made by Professor Sir Stephen Powis, the National Medical Director of NHS England at the 10 Downing Street Press Conference on 25 April 2020 (MH5/42 - INQ000478883; MH5/43 - INQ000478884; MH5/44 - INQ000478886).

83. The Inquiry has asked about the extent to which I considered that public messaging of "*stay at home, protect the NHS, save lives*" or any other public messaging may have deterred patients in need of treatment for COVID-19 or other conditions from seeking care. As discussed above, I was very concerned that those who needed NHS care continued to access the NHS, including online and through NHS 111, hence the messaging described above intended to encourage those who needed the NHS to use it.

Shielding

84. Throughout the pandemic our focus was on protecting those who were most vulnerable to the virus. We knew that a lockdown would pose particular challenges for those likely to be vulnerable to the virus because of age or pre-existing health

conditions. Work on a policy that came to be known as 'shielding' began in February 2020 and was led by Deputy Chief Medical Officer Professor Dame Jenny Harries. I strongly supported the development of the policy.

85. As I explained in my second witness statement, a stay at home policy; social distancing guidance; and guidance on the additional precautions that should be taken by those who were believed to be vulnerable to Covid-19 were agreed at a COBR meeting on 16 March 2020. Shielding was vital for the protection of the most vulnerable. By the time No10 became involved in the policy, significant work had already been undertaken under Professor Harries' leadership. The Government and NHS needed to take urgent steps to identify and assist those who were required to shield, and that communicating with those being asked to shield would be extremely sensitive, as they were many of the most worried about the disease.

86. Data held by the DWP and NHS identified a significant number of the most vulnerable people in the country who needed to shield for twelve weeks. However, there were difficulties in linking data to enable us to contact those individuals and give them the help they needed. This frustrated me, as I felt that data and privacy concerns, whilst important, could not be given priority ahead of saving the data subject's health or even life. I made it very clear, both to NHS Digital, and at meetings of the Health MIG, that I wanted this issue to be sorted urgently. For example, I held a meeting to discuss data protection and security to respond to the pandemic on 10 March 2020 (MH5/45 - INQ000478854) and received advice on this issue on 12 March 2020 (MH5/46 - INQ000478856), which I accepted (MH5/47 - INQ000478857). My Private Secretary received an update about providing notices on 18 March 2020 (MH5/48 – INQ000485148).

87. I was ultimately required to issue four notices under Regulation 3(4) of the Health Service (Control of Patient Information) Regulations 2002 on 17, 20 and 23 March 2020, which directed the NHS to share the relevant data for these purposes (MH5/49 – INQ000485150; MH5/50 – INQ000233781; MH5/51 – INQ000101772; MH5/52 – INQ000485153). These had a very significant positive impact on the ability to deliver services, and one lesson from the pandemic is that this sort of data sharing should become the norm to improve and save lives.

88. Those present at a HMIG meeting on 18 March 2020 decided that the letter to clinically vulnerable individuals should not include a phone number (e.g. for the national call centre) to avoid overwhelming services, but it should include advice on

measures for individuals to take independently before a package of support is in place (MH5/53 - INQ000055912). Ultimately it was possible to include a phone number in the letter as a technical solution to prevent the phone number from being overwhelmed was devised (MH5/54 - INQ000478860).

89. The NHS sent a letter on 21 March 2020 to the 1.5 million individuals identified to be vulnerable and who were required to shield, to explain what they needed to do, and the steps that we were taking to support them, including arranging food and medicine deliveries (MH5/55 - INQ000233778). On 14 April 2020 we brought in Chris Townsend, who had previously led the Government's broadband roll-out, to manage the rollout of the project (MH5/56 - INQ000478873). Chris also did an exemplary job.

90. I was kept updated about changes to criteria for the shielding list throughout my time as Secretary of State. A comprehensive list of these changes is included at paragraph 366 – 390 of Sir Christopher Wormald's fifth witness statement, dated 25 August 2023. We wrote repeatedly to the shielding population, including in specific locations, to explain the latest advice, reiterating advice, underpinned by decisions made on a clinical basis as our understanding of vulnerability to the virus developed. For example, I sent letters with the Secretary of State for Housing, Communities and Local Government, on 22 June 2020 (MH5/57 - INQ000381345), 1 August 2020 (MH5/58 - INQ000058020), 31 December 2020 (MH5/59 - INQ000059396) and 7 January 2021 (MH5/60 - INQ000059496). Professor Harries, Chris Townsend, and their teams deserve significant praise for their work on the shielding programme, which I am convinced saved many hundreds of thousands of lives.

Access to Healthcare

91. I was extremely conscious that performance of non-COVID-19 related healthcare should be monitored closely from an early stage. I was regularly updated on data relating to non-COVID-19 healthcare, which was primarily held by the NHS. I received regular updates on performance, including via submissions, for example (MH5/61 - INQ000391325; MH5/62 - INQ000391337; MH5/63 - INQ000391346), NHS performance data, the COVID-19 Daily Dashboard and at meetings to discuss specific issues. I sent a Whatsapp message to Ministers in the Department on 8 April 2020, asking if there were other health areas that should be discussed at meetings in the Department to consider "non-covid" issues. I had already discussed mental health and maternity services with Departmental officials, and suggested next I wanted to cover cancer treatment and dentistry (MH5/64 - INQ000093270). I received a summary of

NHS performance data on 13 May 2020, and replied the same day asking for this data to be put on the Quad agenda. In my reply I also asked:

> *"Why are we still missing the A&E target?*
>
> *Why are there still 12 hour waits?*
>
> *What can we do to really strengthen 111 so it becomes the first port of call instead of A&E?*
>
> *Is there any way we can measure the health impact of the lack of attendances at A&E? In the paeds meeting today they said that we had only a 5% increases in delayed care. How is that measured? Is there a similar measure here?"* (MH5/65 - INQ000478890)

92. I then attended a meeting specifically to discuss non-COVID-19 A&E attendance and NHS 111 use on 22 May 2020 (MH5/66 - INQ000409864). The Department subsequently produced weekly slides displaying data on the impact of COVID-19 on elective and non-elective care (MH5/67 – INQ000485162; MH5/68 – INQ000485163).

93. NHS111 and the Covid-19 Clinical Assessment Service were significantly expanded to reduce in-person contact between patients and the healthcare service and therefore reduce potential transmission for the virus, and to increase capacity to respond to COVID-19 related demand. I was strongly supportive of these efforts, which were undertaken by the NHS. I also drove work to expand the use of the NHS app.

94. A submission I received on 25 June 2020 recorded that there had been over 645,000 calls about COVID to NHS 111, and GPs working for the COVID Clinical Assessment Service (CCAS) had undertaken over 114,000 assessments (MH5/69 - INQ000478896).

95. When encouraging increased use of technology by GPs, I considered the effects on patient groups who might have issues accessing technology. By its nature it is never possible for all patients to use technology to access NHS services. But this is not an argument against the use of modern technology. On the contrary: by encouraging increased use of technology, this freed up capacity within the system to assist those who would struggle to access technology, or indeed healthcare, for a wide range of other reasons.

96. I have been asked specifically about concerns about a shortage of ambulance drivers. At a meeting on 14 April 2020 I was made aware of issues relating to a shortage of ambulance drivers (MH5/10 - INQ000292607). A note of the meeting taken by my private office records:

" Shortage of ambulance drivers

o Working with DfT about discompensation about asking wider people to be licensed to be able to drive an ambulance, no easy way to do this, needs to be via primary legistlation. May need civil contingencies act

o Currently MOD supporting via MACAs, but this is unsustainable

o CW asked if we can increase testing in this group, KW reported we are doing this already

o CW can we target other C1 driver license holders - KW are currently using fire and rescue services

o EM to work with DfT to see if other drivers (eg horse box drivers) hold the relevant licenses and to use these, if not we will have to change the law."

97. I discussed the issue with senior officials in the Department the next day (MH5/70 - INQ000478877). My Private Secretary's note of the discussion records that I cautioned about letting the perfect be the enemy of the good; this is likely because of the issue noted above about there not being an easy way to expand who is allowed to drive an ambulance, and I likely will have cautioned that we should not let difficulty achieving a 'perfect' solution get in the way of 'good' solutions.

98. We took a series of actions, including a Department for Transport proposal to authorise Fire and Rescue Authorities and Police Forces to conduct driving tests for candidates from the ambulance service (MH5/71 - INQ000478898).

Regulatory regime

99. I supported the CQC's decision to suspend all routine inspection activity. I was supportive of this decision because I wanted hospital and healthcare workers' primary focus to be treating patients, rather than complying with inspection requirements, and to free up inspectors to work directly on the front line. This decision was widely welcomed across the NHS, and undoubtedly freed up resources to support the

pandemic response. My response to this CQC decision recognised that there would be a small number of cases where inspections would remain necessary (MH5/72 - INQ000478858).

100. I have been asked whether the CQC consulted with me prior to taking this decision; the Chief Executive wrote to me on 12 March 2020 (MH5/73 – INQ000485146). On 16 March 2020 I provided feedback to the CQC on letters they had drafted to adult social care and healthcare providers, emphasising the importance of everyone acting in the best interests of the health of the people they serve, with the top priority the protection of life. The CQC accepted these amendments (MH5/74 – INQ000485147).

Ethical Issues

101. I understand that the four nations' chief medical officers commissioned guidance on a prioritisation tool for clinical decision-making in the event of saturation of critical care resources. I did not commission this guidance, and did not see any proposed guidance. I agreed to Chair a ministerial meeting to discuss the potential publication of the guidance, but not its content (MH5/75 - INQ000478908). I became aware through media reports around this time that some organisations such as the BMA were requesting guidance for operational decision making and officials wanted to ensure a comprehensive national framework (MH5/76 - INQ000478863). I did not favour the issuance of a prioritisation tool for access to treatment, and instead was focussed on stopping there being a requirement for such prioritisation by ensuring that demand never exceeded capacity. After agreeing to call the meeting, I spoke to Sir Chris Whitty, and discovered that he too was opposed to the publication of such a tool. His view was that such decisions, where necessary, were best taken on the front line. I agreed with this view, and once I found out I was being pushed to publish guidance that wasn't even supported by the CMO, I cancelled the meeting and blocked the publication of the guidance.

102. This was a real-life replay of an issue that we had trained for. As I discussed at length in my Module 2 oral evidence on 30 November 2023:

> *"The Nimbus minutes demonstrate this -- INQ000195891 -- and the Nimbus minutes do show that the NHS asked the question of how to prioritise when there is insufficient NHS capacity. And there was a debate around that, as you can see, in the minutes, and then I concluded that it should be for clinicians not*

for ministers to make a decision on this basis, and that's how we went on and proceeded. That is -- the minutes are really clear on that, and that is also my clear[…] recollection. But there was really important lesson that came out of Nimbus, which was that there was no way we could allow the NHS to become overwhelmed. So the whole debate for however long it was, an hour and a half, I can't remember the exact length of the exercise, was all about: how do we manage once we're in the peak, when we have all these deaths? And my clear, my only memory -- my only sort of conclusion from it was: we must not let this happen. And of course the question of who decides should there need to be a prioritisation is a horrific one. Thankfully we never needed that."

103. One of the most considerable achievements of the UK during the pandemic was ensuring that the NHS was never overwhelmed, or in other terms, that the NHS was always available to all according to need, not ability to pay, and we did not have to ration care.

104. I was not involved with the Moral and Ethical Advisory Group in relation to the prioritisation tool, or any other matters within the provisional outline of scope for this module. I agreed that summaries of MEAG meetings should be published six months after MEAG meetings had taken place (MH5/77 - INQ000478914).

105. I have been asked specifically about the use of DNACPR notices. My approach throughout was that this is a clinical matter, personalised to the patient, and appropriate consent is paramount. From early April concerns were raised about an overly broad application of DNACPR notices. For example, on 3 April 2020 at the Downing Street press conference which I chaired, with Dame Ruth May, Chief Nursing Officer, and Professor Sir Jonathan Van Tam, deputy Chief Medical Officer, we were asked a question about some elderly and disabled people being told by GPs that "*they fit into the category of do not resuscitate*." This being an operational clinical matter I handed over to Dame Ruth May to answer this question, and she replied:

> "*My clinical colleagues have these discussions all of the time with patients and their families, thinking about their wishes, thinking about what their care being planned, and that's right and proper. COVID-19 is no excuse to have those discussions in an insensitive way, but as these discussions need to happen all of the time with families and with patients themselves.*" (MH5/78 - INQ000478865)

106. On 7 April 2020 the Chief Nursing Officer, England, and National Medical Director wrote to Chief Executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, and providers of community health services; highlighting that 'do not attempt cardiopulmonary resuscitation' ("DNACPR") orders should only ever be made on an individual basis and in consultation with the individual or their family (MH5/79 - INQ000192705).

107. On 10 April 2020 I attended a meeting with officials to discuss what became the COVID-19 Adult Social Care Action Plan. My Private Secretary's note of the meeting records that I commented that the DNR discussion needs to note that for many people not going to hospital is the best decision, but this must be a sensitive, clinical decision based on individual needs and circumstances, not a blanket policy (MH5/80 - INQ000478870).

108. I gave the 10 Downing Street press briefing on 15 April 2020. I announced the COVID-19 Adult Social Care Action Plan, and commented:

> *"And we're making crystal clear that it is unacceptable for advanced care plans, including 'do not attempt to resuscitate' orders, to be applied in a blanket fashion to any group of people. This must always be a personalised process, as it always has been."* (MH5/81 - INQ000478876)

109. I further raised the issue of blanket DNRs at a quad meeting with the Permanent Secretary and Simon Stevens on 7 September 2020 (MH5/82 - INQ000478907).

110. The Minister for Patient Safety, Suicide Prevention and Mental Health Care wrote to the CQC on 7 October 2020 and requested the CQC investigate and report on DNACPR decisions. The CQC issued an interim report in November 2020 and a final report in March 2021.

111. On 17 March 2021 I approved a Written Ministerial Statement in response to the CQC's report, and welcomed the report's recommendation for a Ministerial Oversight Group to drive progress (MH5/83 - INQ000478911). I approved the establishment of the Ministerial Oversight Group on DNACPR decisions on 10 May 2021 (MH5/84 - INQ000478913).

112. I asked that the Department lead on taking forward the CQC 's recommendation that "*People, their families and/or representatives, clinicians, professionals and workers*

need to be supported so that they all share the same understanding and expectations for DNACPR decisions." (MH5/85 - INQ000478910)

113. I approved a response to a Coroner's Prevention of Future Deaths report which raised concerns about the application of DNACPR forms by paramedics in cases of self-harm and attempted suicide. The response refers to the CQC review commissioned by the Department (MH5/86 - INQ000479883; MH5/87 - INQ000479884; MH5/88 - INQ000479885; MH5/89 - INQ000478912)

Nosocomial Infections

114. I was acutely aware of the risk of nosocomial (hospital-acquired) infections for patients and staff from an early stage. We discussed this problem regularly. For example, Lord Bethell, who was leading on testing, raised concerns about 'in-hospital contamination' on 22 March 2020 (MH5/90 - INQ000478862). I was concerned throughout about reducing the spread of the virus as much as possible. My drive to expand testing, particularly of health and social care staff, and vaccination of NHS and social care staff, were all part of efforts to reduce nosocomial infection.

115. I discussed nosocomial infections frequently with Sir Simon Stevens and Dame Ruth May. I held a meeting specifically to discuss the issue of nosocomial infections on 11 June 2020 (MH5/91 - INQ000478894) and I pushed for us to look at data on the impact of the use of masks in hospitals on infections.

116. Data relating to nosocomial infections was specifically discussed at a meeting about NHS data on 16 November 2020 (MH5/92 - INQ000478909). The note of that meeting records "*Amanda Pritchard and Ruth May outlined nosocomial measures and noted nosocomial data was consistently used to influence policy - identifying outliers and implementing best practice*." One action from the meeting was to improve or adjust the way data was shown on some charts, for example to show nosocomial infections using a metric which adjusted for hospital size and community prevalence. It was hoped that seeing nosocomial infections within context would help identify specific hospitals where there might be infection control issues.

117. I raised the issue of nosocomial infections repeatedly at quad meetings with Sir Simon Stevens and Amanda Pritchard, see for example the records of meetings on 18 May 2020, 1 June 2020 and 8 June 2020 (MH5/93 - INQ000478891; MH5/94 - INQ000478892; MH5/95 - INQ000478893). I have been asked about the causes of

nosocomial infection. On this I took advice from the CMO, Dame Ruth May and others. I recall that we considered that patients and staff were two major contributors to nosocomial infection, not least since visiting had been significantly restricted. Of course it is impossible to know with certainty where any one person caught such a transmissible virus.

118. My concern about nosocomial infections was because of concern about both patients and healthcare workers contracting Covid-19. I have been asked about any concerns which I was made aware of regarding the adequacy of ventilation in hospitals. I was highly concerned about infection control and prevention in hospitals, including appropriate ventilation, though this is and was of course a matter for the NHS.

Testing

119. The provision of testing in hospitals was a very important matter, on which the NHS led. Clearly, the primary consideration was the overall availability of tests. As discussed in my second witness statement, we increased testing capacity to 10,000 per day by the end of March. From 17 March onwards, testing provision was developed in five "pillars". The NHS's own internal capacity was part of pillar 1 and managed by the NHS themselves. As we built capacity, clinical prioritisation determined availability. This clinical prioritisation recognised the risk that individuals faced, as well as the risk that they posed to vulnerable individuals within their care (MH5/96 - INQ000233780). NHS staff were within first group of key workers to whom testing was made available, estimated to require 250,000 tests per week in England, which would require approximately 36,000 tests per day. While availability was vital, so too was uptake.

120. Huge numbers of people went out of their way and delivered against the odds to expand testing, in a way they simply had not before. Professor John Newton's blog sets out the important context of how the team achieved this in the face of very little capacity from the start (MH5/97 - INQ000233805). The UK entered the pandemic without the diagnostics capacity needed to deal with outbreaks, and by 18th May 2020 everyone aged 5 and over with symptoms of Covid-19 was eligible to be tested.

PPE

121. As I described in my second witness statement, on 30 January 2020 I received PHE's audit of the PPE stockpile: it said that there was no clear record of what was in the stockpile and that some kit was past its best before date.

122. On that date I instructed officials to work out what we needed fast and to buy in huge quantities. A 'supply chain cell' was set up to address the issue and I understand that it met for the first time on 1 February 2020 (MH5/98 - INQ000233750). Cabinet Office led on contractual matters, and the Department, Cabinet Office, NHS and others worked together to buy PPE in a context of massive global demand.

123. On 5 March 2020 I had communication from Helen Whately to say that the PPE supply to care homes was inadequate. I told her that the Department had to get PPE to wherever it was needed, not just hospitals. The challenge was logistics; NHS Supply Chain, the company that delivered PPE to hospitals, had never seen so much demand and were really struggling.

124. It quickly became clear that one failure of preparation was that the stockpile of PPE was not spread across the country, local stockpiles were almost non-existent, and little consideration had been given to the rapid distribution of PPE in a crisis. I was told that the warehouse which held a very significant stockpile had only one main door, which slowed the distribution of PPE.

125. Alongside the Government guidance to the public, for example, the 4 March 2020 campaign about handwashing, the NHS changed its protocols for PPE on 6 March 2020 and 13 March 2020 (MH5/99 - INQ000339123; MH5/100 - INQ000325350). I accepted their proposals for new PPE guidance. However, we also knew that the consequence of the new guidance would be to further increase demand for PPE. The Department therefore had to take additional action to try and speed up PPE distribution to NHS trusts, some of which had already reported shortages. I was aware of media reports at the time of instances in which shortages had forced NHS staff to wear makeshift PPE, which is one reason why we were doing everything we could to get PPE to the front line.

126. Formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the

Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

127. While we had been buying PPE in anticipation of these problems since January, the procurement of additional PPE became exceptionally difficult at this time, as many other countries also began purchasing in very large scale. These difficulties were exacerbated by our public procurement rules, which required the Government to make purchases at the bottom quarter of the market pricewise. Whilst those were eminently sensible rules for ordinary times (respecting that public money needed to be spent carefully and with an eye on value for money), this restriction put the UK on the back foot as global prices for PPE soared.

128. When I found out about this bottleneck I indicated that any PPE that could be found should be purchased, irrespective of its price point: my view was that we needed everything we could get. After consideration, HMT signed off the move to emergency procurement procedures, which were designed for this eventuality. Significant cross Government effort, led by a combination of Cabinet Office, NHS England, FCDO and DHSC staff, went into the efforts to purchase extra PPE. The Prime Minister made a public call for help from those who could buy or produce PPE, and a system was put in place to handle the many responses we received from this call to action.

129. I cannot comment on individual purchase decisions as I was not involved in any contracting, pricing, or purchasing decisions – these decisions were made by civil servants, largely from the Cabinet Office. A huge team of people worked incredibly hard to respond to a Prime Ministerial call to action to do their duty in the national interest. The only alternative to buying expensive PPE was not to buy PPE, which would have cost lives.

130. Data about PPE was first incorporated into the Covid-19 dashboard on 21 March 2020 (MH5/101 - INQ000283617).

131. I understood 'stock out' to mean the point at which we would be out of stock of certain products. For example, on 13 April 2020 my private office asked about 'gowns stock-out'. I was assured that we had enough gowns, and that though the dashboard would

show that tomorrow we were out of stock, as we currently had "*c60k and need to send out c60k… a delivery of another 60k is expected.*" (MH5/102 - INQ000478872). While individual shortages of supply were apparent, at no stage was there a national shortage. There were of course reports circulated online of individual shortages. We acted wherever we could to address such shortages. For example, the Inquiry has asked me about a news article from the Daily Telegraph, first published on 8 April 2020 which refers to nurses at Northwick Park hospital. I presume that I saw this media reporting at the time, as on the same day I asked officials to find out when Northwick Park hospital had last had a delivery of PPE, and when their next order was due. Officials confirmed that deliveries of PPE were being made to that hospital's consolidation centre daily, and that the consolidation centre had reported that day that they did not need any further supplies of aprons or masks (MH5/103 - INQ000478866). In some cases we discovered that the reports of individual shortages widely reported online were in fact from overseas.

132. On 20 April 2020 I asked that the dashboard better present the PPE stock picture, to better capture the full story of what was going on. In response officials suggested they would include the daily and weekly requirement number for each item, the daily stock position that we had on hand each day, and the 7 day supply forecast for each item, with a confidence level attached (MH5/104 - INQ000478881). This was because the dashboard had been presenting estimated days until 'stock out' based on initial modelling, but did not account for anticipated supply. For example, the dashboard may included that we only had a certain number of days until stock out of an item, but we knew that we were about to receive a large delivery of stock of that item.

133. I have been asked about a line in the exhibited email (MH5/104 - INQ000478881), which I did not write, "*One of the main issues is that this is an area where a single number or graph will ever be able to capture the full story of what is going on, however we also want to be able to minimise the follow up questions that certain information will lead to from CCS.*" I suspect that this is a reference by the author to the Civil Contingencies Secretariat asking follow-up questions about stock of an item where it appeared stocks were low, but the Department was already arranging to procure more supply, and this wasn't reflected on the dashboard.

134. Throughout we considered the question of the need to offer a range of PPE to all NHS and social care staff, from all backgrounds, to fit a range of needs. For example, in June 2020 we launched a FFP3 mask fit-testing project, led by the Deputy Chief Nursing Officer. We introduced eight further types of mask in response, to provide

staff with the widest possible range of masks to choose from (MH5/105 - INQ000354552).

135. We also procured alternative produces, for example powered respirators, which those unable to fit-test well against masks were able to use.

136. Chapter 6 of the Department's PPE Strategy, published in September 2020, outlines our learnings about user experience and how the Department was incorporating user feedback into its approach to PPE, including feedback about user comfort, gloves and clear facemasks (MH5/106 – INQ000339271). The Strategy describes how one supplier visited four NHS trusts to understand staff needs, concerns and requirements to tailor the introduction of new respirators.

137. I have been asked whether I consider that there were appropriate processes or procedures within the healthcare system for those using PPE to provide feedback about the quality and suitability of the PPE they were using; and any other concerns they had about PPE. The Department made extensive efforts to address concerns about PPE, including from front line staff, during the pandemic. I regularly spoke to Dame Ruth May, who reported both to me and the Chief Executive of NHS England about this subject. Formally, the National Social Partnership Forum is the established mechanism for the Department to discuss issues affecting staff, and brings together the Department, the main healthcare trade unions, NHS employers and arms-length body partners. The Forum discussed issues relating to PPE regularly and particularly how staff concerns could be addressed.

Other Supply Issues

138. I attended a COVID-19 supply update meeting on 12 March 2020 and was provided a full update on steps taken to source enough oxygen. I encouraged officials to look at temporary measures to increase oxygen supply, but building oxygen supply capacity is complicated, so I was also content for the NHS to prioritise sending patients to a location where oxygen is most easily admitted and readily available (MH5/107 - INQ000479882).

139. There was an issue with oxygen supply at Watford General hospital on 4 April 2020. I can see that Sir Simon Stevens sent me a Whatsapp message about the incident at 4.30pm that day, so we must have discussed it. I understand that the hospital re-opened the next day. I approved a request from Watford General to send engineering-qualified army personnel to the hospital to assist the hospital's estates team (MH5/108 -

INQ000478867). I received an update on oxygen distribution from officials on 9 April 2020 (MH5/109 - INQ000478868).

Medication

140. As with global competition to procure PPE, there was also global pressure to secure medicine supplies. For example, at an update meeting on 14 April 2020, officials told me that we had a four-day supply left of drugs needed in intensive care, that an alternative drug had 6-10 days of supply left, and this was a Europe-wide issue (MH5/10 - INQ000292607).

141. I regularly reviewed medicine supply, for example (MH5/110 - INQ000478905). Steve Oldfield led for the Government on medicine supply. Thanks to the exemplary work he had led in preparation for the risk of a no-deal Brexit, we had more visibility of medical supply chains than ever before.

142. A further example is provided by the briefing provided by officials about how they managed supplies of neuromuscular blocking agents, opioids and sedatives, which were being used in ventilated COVID-19 patients. The briefing notes:

> *"supply was managed centrally and regionally, working closely with the Regional Chief Pharmacists and Regional Pharmacy Procurement Specialists in England and with National Procurement leads in the Devolved Administrations. The situation has been improving steadily since May 2020, but we are continuing to monitor supply. More generally, as part of our concerted national efforts to respond to the coronavirus outbreak, we are doing everything we can to ensure patients continue to have access to safe and effective medicines. The Department continues to work closely with the pharmaceutical industry, the NHS and others in the supply chain to help ensure patients can access the medicines they need, and precautions are in place to reduce the likelihood of future shortages. The Department shares regular information about impending supply issues and management plans with the NHS via networks in primary and secondary care and will liaise with relevant patient groups about issues affecting specific medicines. In addition, the Department is launching a procurement exercise to build a stockpile of Covid-related drugs."* (MH5/111 - INQ000478904)

Visiting Restrictions

143. Visiting guidelines or protocols were a matter for NHS England. I was concerned about nosocomial infections, see paragraphs 114 to 118 above, and asked specifically about visiting rules for Nightingale Hospitals and ITUs in April 2020 (MH5/112 - INQ000478871).

Long Covid

144. As I explained in my third witness statement, in April 2020 I was aware of public discussion of post viral fatigue, and in May 2020, I became aware of the term, Long Covid, emerging as people shared their anecdotal experience about their failure to recover. I also know people who had (and still have) longer term symptoms and therefore I believed that something needed to be done.

145. I requested NHS England consider what we must do. I asked Sir Simon Stevens to develop plans for provision for those suffering with Long Covid in May 2020, and on 1 June 2020, I was sent the final draft for review of the NHSE guidance on the long-term healthcare needs of Covid-19 patients and the recommended actions for healthcare providers to meet those needs (MH5/113 - INQ000292618; MH5/114 - INQ000292619; MH5/115 - INQ000292620). The guidance was published on 5 June 2020 (MH5/116 - INQ000050846).

146. On 5 July 2020, I announced that a major new UK research study - the post-hospitalisation Covid-19 ("PHOSP-COVID") study - would be carried out by the National Institute for Health Research ("NIHR") together with UK Research and Innovation ("UKRI") to understand and improve the long-term health impacts of Covid-19 (MH5/117 - INQ000283372). It was supported by the award of a £8.4 million funding package. On the same day NHSE announced its 'Your Covid Recovery' service which was an online rehabilitation service that provided, a bespoke interactive package of online-based aftercare to assist their recovery (MH5/118 - INQ000283370).

147. On 31 July 2020, I convened and chaired an expert roundtable to discuss Long Covid (MH5/119 - INQ000292625; MH5/120 - INQ000292627; MH5/121 - INQ000292628; MH5/122 - INQ000292629). The objective of the roundtable was to identify what further research was required to investigate and mitigate the long-term impact of Covid-19 on survivors. The roundtable was attended by the Deputy CMO

("DCMO"), Professor Dame Jenny Harries, directors from NHSE, various clinical experts and academics and a number of observers from the Department and UKRI. I set out during the meeting my view that there was a need for further research in the community to understand and improve the longer-term effects of the virus in those who did not require hospitalisation. I strongly supported these conclusions, and acted upon them.

148. By September 2020, I remained concerned that more needed to be done in respect of those people suffering long-term symptoms who had not been hospitalised (MH5/123 - INQ000218365; MH5/124 - INQ000292630). On 15 September 2020, we discussed at a Quad meeting the clear need to rapidly establish a significant cross-cutting programme of work on the long-term effects of Covid-19 which ensured there was better integration between primary and secondary care so as to better understand the incidence and long-term effects of Covid-19 (MH5/125 - INQ000292631; MH5/126 - INQ000292632; MH5/127 - INQ000292633). I pressed the need to make progress on this work at a meeting of departmental leaders on 22 September 2020 (MH5/128 - INQ000292638).

149. Lord Bethell took this work forward (MH5/129 - INQ000292634; MH5/130 - INQ000292635; MH5/131 - INQ000292636; MH5/132 - INQ000292637). On 28 September 2020, Lord Bethell held an internal roundtable on Long Covid (MH5/133 - INQ000292639). This led to the introduction from 13 October 2020 of a series of monthly external roundtables which continued throughout the pandemic (MH5/134 - INQ000058536). They were attended by patient representatives, clinicians, ministers, departmental officials and other key stakeholders to discuss the challenges, ongoing research, emerging data and issues so as to shape the response to Long Covid. I understand the minutes of those roundtables will be produced to the Inquiry separately by the Department.

150. On 7 October 2020, NHSE announced that £10 million would be invested as part of a five part plan to boost NHS support for Long Covid patients (MH5/135 - INQ000283373):

    a. New guidance to be commissioned by the National Institute for Health and Care Excellence ("NICE") by the end of October 2020 on the medical 'case definition' of Long Covid;

b. 'Your Covid Recovery online rehabilitation service to continue providing personalised support to patients;

c. Establishment of specialist Long Covid clinics across England to provide joined-up care;

d. NIHR funded research on Long Covid working with 10,000 patients to better understand the condition and improve treatment; and

e. Establishment Long Covid Taskforce to include patients, medical experts and researchers.

151. On 21 October 2020, we launched a film about Long Covid in which I warned of the long-term effects of Covid-19 as a means of underlying the importance of complying with social distancing measures (MH5/136 - INQ000283375). This reflected that the best way of preventing people from suffering Long Covid was to prevent them from contracting Covid-19 in the first place.

152. On 12 November 2020, UKRI and NIHR launched a £20 million joint research call to fund research into the longer term physical and mental effects of Covid-19 in non-hospitalised individuals (MH5/137 - INQ000283379). In response to the call, on 18 February 2021, £18.5 million was awarded to four new research studies aimed at better understanding and addressing the long-term health effects of Covid-19 (MH5/138 - INQ000283412). Further to NHSE's announcement on 7 October 2020 (paragraph 11 above), on 16 November 2020, I announced that the NHS were to launch a network of 40 specialist Long Covid clinics within weeks, bringing together doctors, nurses, therapists and other NHS staff to help those suffering with the long-term effects of Covid-19. This announcement built on the Long Covid clinics already up and running (MH5/139 - INQ000292641).

153. On 18 December 2020, NICE published guidance on the identification, assessment and management of Long Covid (MH5/140 - INQ000283459).

154. On 29 January 2021, I was sent a briefing on Long Covid and, in particular, progress against the NHS five-point plan (MH5/141 - INQ000292647; MH5/142 - INQ000292648). It noted that, by that stage, the number of specialist Long Covid clinics had increased to 69 with further to launch. It also stated that the assumption, based on early literature, was that about 2% of all those infected warranted assessment in a Long Covid clinic, with a gradual capacity ramp-up. This reflected

the capacity constraints at the time and the time required to establish Long Covid services.

155. On 17 February 2021, I attended a pre-briefing meeting for the fifth Long Covid roundtable meeting (MH5/143 - INQ000292652). I then chaired the roundtable on 23 February 2021 (MH5/144 - INQ000292653; MH5/145 - INQ000292654; MH5/146 - INQ000060080). I noted that, while much progress had been made, there was much to be done. In particular, there was a need for the NHS to set their future direction in respect of Long Covid on further research, tackling health inequalities and broader rehabilitation services. I committed to continuing to drive the Long Covid agenda forward.

156. On 26 February 2021, I was provided a note on the NIHR strategy for developing Long Covid research (MH5/147 - INQ000292655; MH5/148 - INQ000283416). Following which, on 25 March 2021, the NIHR launched a second call for research proposals on helping and supporting people with Long COVID (MH5/149 - INQ000283429). I pressed for the research to be carried out at pace (MH5/150 - INQ000292658).

157. At a Quad meeting on 29 March 2021, I urged the maintenance of funding for Long Covid treatment (MH5/151 - INQ000292657).

158. From April 2021, the Office for National Statistics ("ONS") began to publish estimates of population prevalence of Long Covid in the UK which added to our understanding of the proportion of people affected and the demographics (MH5/152 - INQ000292660).

159. On 11 June 2021, I attended a Long Covid update meeting (MH5/153 - INQ000292661). It was noted that there were currently 80 Long Covid specialist clinics. I was provided with an update on the response to NIHR's research call, which had received over 70 applications. I was also updated as to the progress of NHSE's Long Covid Plan for 2021/2022 for which they had already announced £24 million investment with a further £124 million proposed. NHSE published 'Long COVID: the NHS plan for 2021/22' later that month (MH5/154 - INQ000283498).

Healthcare staff

160. The Prime Minister asked the Home Office and DHSC to exempt health and care workers from the NHS immigration health surcharge on 21 May 2020. I announced

that the Prime Minister had made this request at the 10 Downing Street press conference that day.

161. During the press conference I discussed the enormous contribution that people from overseas make to the NHS and to social care. I explained that the purpose of the immigration health surcharge within the NHS is a fair one, to ensure that everybody contributes to the NHS, but that those who work within the NHS social care make that contribution directly (MH5/155 - INQ000478915).

162. I agreed that Lighthouse Lab workers also be exempt from the immigration health surcharge (MH5/156 - INQ000478903).

163. I received notes on the practical implementation of the exemption in June and July 2020 (MH5/157 - INQ000478895; MH5/158 - INQ000478897; MH5/159 - INQ000478899; MH5/160 - INQ000478900). I then approved the Department's approach and a Written Ministerial Statement (MH5/161 - INQ000478901; MH5/162 - INQ000478902).

Vaccination as a Condition of Deployment

164. In December 2020 I had heard anecdotal reports that younger care home workers were reluctant to have the vaccine. Understandably, operators were worried about their legal position, for example, if an unvaccinated carer brought Covid into a home and infected a resident.

165. In my view it is entirely reasonable to require all health and care staff to be vaccinated when scientifically validated vaccines are available, except for those with genuine medical exemptions. This is, for example, the principle by which the hepatitis B vaccination is already mandatory for doctors. People providing care should take credible, scientifically valid steps like this to reduce the risk of harming those in their care.

166. As I discussed in my second witness statement, the Prime Minister and I had discussed making flu and Covid-19 vaccinations a condition of work for all care home workers. On 17 March, at a Ministerial meeting of COVID-O, it was agreed that the Government should proceed to take steps to make vaccination a condition of deployment, while also working on non-legislative solutions in the interim, including the assessment and mitigation of any particular impacts on disproportionately

impacted groups: (MH5/163 - INQ000092064; MH5/164 - INQ000091817; MH5/165 - INQ000234310).

167. I have been specifically asked about "*the practical difficulties with a significant reaction likely from a small minority*" (MH5/163 - INQ000092064). Unfortunately, even some health and care workers buy into the dangerous conspiracy theories about vaccines, and so are hesitant or resistant to taking them. Unfortunately, unions representing some healthcare workers too often represent these irrational minority voices, rather than the mainstream opinion and scientific facts which underpin the value of vaccination. I have no idea why the consultation on further steps towards vaccination as a condition of deployment were not taken forward, but I imagine these reactionary pressures are likely to be a reason.

168. This remains a live issue. In May 2024 the BBC reported an NHS hospital has flu vaccine uptake of under 50%. This represents a serious clinical risk, and if not addressed is likely to increase nosocomial infections, and people will die as a result. This single example reinforces the very strong case for all frontline healthcare workers to be required to be vaccinated against dangerous transmissible diseases like Covid-19 and flu as a condition of deployment, to reduce the risk of harming the very patients they should care for. This policy has been implemented in social care. There are no rational reasons against such a policy across the entire NHS.

Equalities

169. As mentioned in paragraph 17 above, our purpose throughout the pandemic, including in trying to determine who was most vulnerable to the virus, and instigating the first lockdown, was to protect those in society most vulnerable to the virus. Considering the effect of policy decisions on the vulnerable was at the heart of the Government's strategy. My overall priority was to protect health and well-being. The actions we took to stop the spread of the virus, protect people with vaccines, instigate a huge shielding programme, and ensure the NHS was never overwhelmed all considered the needs of minorities, and disproportionately benefitted vulnerable minorities.

170. I considered the impact of my decisions upon disabled people, people who were clinically vulnerable, clinically extremely vulnerable and severely immunocompromised, those from minority ethnic backgrounds or lower socio-economic backgrounds and/or other groups with existing health inequalities throughout the pandemic. Indeed many of the decisions we made were put in place

precisely with their protection in mind. I received expert advice from world-leading clinicians, including the CMO, on how to reduce the unequal impact of the pandemic. I also received impact assessments and equality impact assessments from Departmental officials. The effect of this advice was to reinforce my decision to try to limit the spread of the virus, increase NHS capacity and find a vaccine as quickly as possible, in order to protect all members of the public and particularly those worst-affected by the virus.

171. As I set out in my second witness statement, for example, I stated that I wanted SAGE's advice identifying risk factors for the outcome of contracting covid from 7 April 2020 published so that those who were at risk of particularly acute effects of a COVID-19 infection were aware of this, and could take precautions accordingly.

172. I had received a briefing on emerging evidence on obesity and COVID-19. As discussed in paragraph 25 of my third witness statement, I was concerned about the unequal impact of the virus across wider society, particularly given that the first doctors to die in the UK from the virus were all from ethnic minority backgrounds and I had received an update from the CMO prior to the circulation of the minutes of the 16 April SAGE meeting where it had been identified that black people had a higher risk of being admitted to hospital and of dying, and that a disproportionate number of BAME healthcare workers were dying (MH5/166 - **INQ000075780** I was worried by this data, and recall discussing it with the CMO.

173. Upon my request, the CMO commissioned PHE to report on disparities in outcomes and risks from COVID-19. On 30 April 2024 I asked my special adviser to share these concerns with the media so that the public would be aware that we were taking action to look at and try to understand the basis of these potential risk factors (MH5/167 - INQ000478888; MH5/168 - INQ000478889). On 12 May 2020, PHE provided a rapid interim review on the current data already available on ethnicity and health outcomes and the CMO sent me a note on the same (MH5/169 - INQ000233807; MH5/170 - INQ000233808; MH5/171 - **INQ000069220** MH5/172 - **INQ000069223**; MH5/173 - **INQ000069218**). I also read Ben Goldacre's excellent work on these matters, which analysed the disproportionate instances of Covid-19, and highlighted the differential risks faced by different people according to their characteristics. Understanding this – and what we could do about it - was at the front of my mind throughout.

Lessons learned

174. I would draw the Inquiry's attention to my second witness statement, which outlines in great detail the lessons I think can be learned from the pandemic. In particular, I would note my comment at paragraph 680 of that statement, that preparations should be in place for the myriad operational requirements that must be capable of being expanded rapidly. This is true of supply issues relating to a whole range of necessary products, and the ability to expand NHS capacity at scale.

175. I would also reiterate my comments at paragraph 88 above about the importance of data sharing to deliver public services.

176. Further, I would strongly recommend that clinically approved vaccines be made a condition of deployment for health and care staff to protect them and those in their care.

177. Finally, I would strongly recommend that an early objective of any future pandemic is to make sure the NHS is never overwhelmed. The terrible impact of any pandemic is going to be worse if there is not access to healthcare. We should learn the lesson from the success of the UK's provision of healthcare. No-one was charged for healthcare. Unlike in other countries, care, tests and vaccines were given out for free to all residents when they were available. Most fundamentally, thanks to the hard work of millions, the NHS was able to live up to its founding promise of healthcare, free at the point of delivery according to need, not ability to pay.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Dated: 12 June 2024